A STUDY OF THE UTILIZATION OF THE ARMY HEALTH NURSE BY INSTALLATIONS CONDUCTING AN ARMY HEALTH SERVICE

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Unlimited

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A Study of the Utilization of the Army Health Nurse by Installations Conducting an Army Health Service

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INTRODUCTION

On 27 June 1950, Army Regulation 40-50 was published which established a new field in Army Nursing, that of the Army Health Nursing Service. Since that time programs have been instigated at numerous Army installations and are moving slowly, but surely, toward the accomplishment of an established goal - that of maintaining the highest level of individual health within the command.

As with all new programs, the course of the Army Health Nursing Service has not always been a smooth one. AR 40-50 was written to provide a high degree of flexibility to meet any situation for the Commanding Officers establishing the programs. Unfortunately, the result has been a wide variation in the interpretation of the regulation. Consequently, the burden of the implementation in many cases rested with the nurse herself, particularly where the Commanding Officer was neither public health minded nor especially enthusiastic regarding the success of the program. We, as Chief Nurses and Nursing Service supervisors have been bombarded with questions, for which we were unable to find answers. Because of the lack of definitive knowledge of the functions of the program it seems to be the feeling of some that the Army Health Nursing Service is an additional drain on the already numerically inadequate nursing staff and is considered a loss rather than a gain in patient care.

In some instances, the Chief of Preventive Medicine lent invaluable aid to the pioneer health nurse, showing considerable interest in the establishment of the program and making many sound

helpful suggestions. This liaison planted a seed, which is now maturing in many minds - that the Army Health Nurse should be assigned in the Preventive Medicine Branch, separated entirely from the hospital and under the direction of the Chief of Preventive Medicine.

Our interest in the Army Health Nursing Service was aroused through conversations with Army Health Nurses who were becoming discouraged because of the many problems they were meeting and the fact they seemed to have no one they could rely on for supervision. Many Chief Nurses and supervisors also have confessed their ignorance of their relationship to the program.

Purpose of the Study:

The purpose of this study is to gain an insight into the Army Health Nursing Service, the progress and the situation of the Army Health nurse, and to present factors that are involved in her problems in establishing and maintaining the program.

Justification of the Study:

The fact is recognized that the Army Health Nursing program presents many problems. This study was done to point out the need for and to justify the assignment of a qualified professional public health nurse to the Army Health Nursing Service.

All data was collected by questionnaire from the Army Health nurses actually assigned to Army Health programs in all the Army Areas.

DEFINITION OF TERMS

For the purpose of this study the following terms and their meanings are listed below.

Army Health Nurse: A qualified professional nurse who is assigned to do specialized nursing duties with dependents of military personnel to promote a well rounded family health service.

To qualify as Nurse, Army Health Service, MOS 3431, she must be a graduate registered nurse from an approved school of nursing, and have completed one of the following educational requirements:

1. A minimum of 2 years experience under a qualified nursing supervisor in a Public Health Agency in which family health work is emphasized.

2. A year's program of study at a university which offers a course in Public Health Nursing, plus an additional 6 months of supervised experience in a Public Health Nursing Agency.

3. A graduate from a university school offering a degree in nursing with a program approved by the Surgeon General's Office.

4. A baccalaureate degree with a Major in Public Health Nursing.

Army Health Nursing Service: The program established by the Commanding Officer of an installation, whenever he deems such action advisable for the purpose of maintaining the highest level of individual health to those authorized medical care within his command. This service is carried out by the Army Health nurse under the direction of a medical officer.

Army Regulation 40-50: Army Regulation 40-50, Dept. of the Army, published 27 June 1950, which authorizes the establishment, defines the responsibilities, the administration and qualifications of personnel and maintenance of records of the Army Health Service.

Case finding: The effort put forth by the individual nurse in the seeking out of situations which require assistance and guidance in facilitating recovery and in maintaining health and prevention of disease within the home.

Criteria: Standards of judging; rules or tests by which facts, principles, opinions, and conduct are tried in forming a correct judgment respecting them; standards employed in matters of judgment, as of facts.

Daily Bulletin: An information sheet which contains official and unofficial information - normally published daily at a specified hour so as to be distributed by noon.

Evaluation: Ascertaining the amount of or value of; to appraise carefully.

Family folders: A record that is maintained by the Army Health nurse to include pertinent data of each family regarding the visits and service rendered, and a source of information in planning for family care.

In-Service programs: An educational program conducted within the command for administration information and instruction of military personnel.

Installations: Military posts, camps, or stations.

Instructional visits: A visit made in the home to teach.

Local Health Agency: A city or county health agency.

One visit: The initial home call made by the Army Health Nurse.

Supervision: A cooperative process that has as its objective the improvement of nursing service achieved by the fullest possible development of all of the staff members.

Public Health Nurse: A graduate professional nurse who has advanced training in Public Health, to function as an integrated member of a health service to build healthful living within a community by counselling, guiding and teaching individuals and families prevention and control of disease and the maintenance of health.

Visiting nurse: A graduate professional nurse who does bedside nursing, demonstrations and treatment in the homes under the direction of a physician.

Manual: Prescribed procedures in the form of a hand book.

MOS: Military Occupational Specialty.

Orientation: Determination or sense of one's position with relation to environment or some particular field of knowledge.

Preventive Medicine: Supervision of sanitary arrangement of a command and the measures that are taken to prevent the spread of disease.

TIP: Troop Information Program.

REVIEW OF RELATED LITERATURE

Many books and articles can be found on Public Health Nursing, but on the newly established Army Health Nursing Service very little has been written and published to date.

Army Regulation 40-50, 27 June 1950 was used as a guide as it is the regulation governing the authority for establishment of the program, defines its functions, and qualifications of the nurse.

Technical Manual 12-406, Officers' Classification, Change 4, 7 August 1950 was also an aid as it gave a detailed job description for the nurse and published the establishment of the Military Occupational Specialty Number, 3431, Nurse, Army Health Service.

After a thorough search it was found that a paper written by Lt. Colonel James P. Pappas, MC, United States Army, published in the Bulletin of US Army Medical Department on the "Role of the Visiting Nurse on a Military Post" was helpful, in that it described how a well functioning health program did operate.

The above mentioned references exhausted the literature directly relating to this study.

HYPOTHESIS

To guide the direction of the study and the method of procedure two working hypothesis were formed by the committee.

1. That the Army Health Nurse is not being utilized to her fullest capacity in a complete Health Service.

2. That there is a lack of knowledge and understanding on the part of all military personnel in regard to the Army Health Service due to inadequate orientation as to the purpose of the program, which is to maintain the highest level of individual health.

CHAPTER III

SECTION IV - SUMMARY AND CONCLUSIONS

Responses on questionnaires show that from 82% to 92% of the Commanding Officers, Chief Nurses and Staff nurses have been cooperative in maintaining the Health programs. On almost every post where the Army Health nurse has the cooperation of these people the program has few problems in the administrative field.

It is interesting to note that the percentage of non-cooperative Commanding Officers (3.6%) is felt by the nurses to be due to the lack of orientation to the purpose of the total program at Army level, and points out the need for more definite policy interpretation of Army Regulation 40-50.

An attitude of indifference to the program was reported in 14.3% of Commanding Officers, Chief Nurses and Staff Doctors, and in 10.7% of the Staff nurses. The general feeling of the Army Health nurses and of this committee is that orientation to the program was inadequately carried out to the hospital personnel - that they do not use the program properly because they do not understand it, rather than actually being indifferent to it.

A small percentage of Doctors, Staff nurses and families (3.6% of each), were reported as being unaware of the Army Health program, which this committee feels, points again to lack of proper orientation to both contributing and using agencies. (See Table 18)

TABLE 18

ATTITUDES

Encountered by the Army Health Nurses in Maintaining Programs

Personnel	Cooperative		Non Cooperative		Indifferent		Not Aware of Health Program	
	Number	%	Number	%	Number	%	Number	%
Commanding Officers	23	82.1	1	3.6	4	14.3		
Chief Nurses	24	85.7			4	14.3		
Staff Nurses	24	85.7			3	10.7	1	3.6
Doctors	23	82.1			4	14.3	1	3.6
Families	26	92.9			1	3.6	1	3.6
Community	25	89.2			1	3.6	2	7.2

The above data as taken from questionnaires shows the percentage of cooperativeness of concerned personnel. There appears to be close correlation between the cooperative Commanding Officer and his Staff Doctors (82.1% - as well as between the Chief Nurse and her Staff nurses (85.7%). The families show highest degree of cooperation (92.9%), followed by the community (89.2%).

Only a small per cent(3.6%) of Commanding Officers were reported as actually non-cooperative - this program had administrative difficulties. This Commanding Officer was also the Post Surgeon.

Ir titude of indifference of Commanding Officers, Chief Nurses, and Staff Doctors (14.3%) each, again showed close correlation. But the Staff nurses showed less indifference - only 10.7%. Only one nurse reported indifference on the part of families and community (3.6% of each).

In the data no Commanding Officers were shown as unaware of the

program, but Staff nurses, doctors and families (3.6% of each) and 7.2% of communities were cited - which again points to inadequate orientation.

This committee felt the degree to which the Army Health nurse herself thought she was being used was important. Where the nurse reported maximum use, 57.1% felt they were, the programs seem to be functioning smoothly and show plans for extending their scope. These nurses also feel they need more help. Several asked for another full time Army Health nurse, one requested clerical help and another requested non-professional aid - especially in their clinics.

Where the nurses reported minimum use, 14.3%, their programs were recently organized and as yet not functioning near capacity. These nurses are tied up much of their time acting as Out-Patient Department nurses and haven't the time to organize their instructional classes or school programs.

The nurses who answered they are being used only partially, 28.6%, are the group who are being assigned and used almost completely as Out-Patient Department nurses. Though only eight nurses reported partial use on studying the questionnaires many more than eight reported being used as relief nurses on hospital wards and one reported being assigned to "specialling" seriously ill patients as the need arose. These programs show definite lack of continuity and have many problems.

The following table (Table 19) shows at a glance the degree of use the present Army Health nurses are being used.

TABLE 19

DEGREE TO WHICH THE ARMY HEALTH NURSE FEELS SHE IS BEING USED

Degree of Use	Number	%
Maximum	16	57.1
Minimum	4	14.3
Partial	8	28.6

These figures were compiled from data collected. The 57.1% reporting maximum utilization as Army Health nurses in most instances show quite complete programs - also show apparent correlation with programs in effect the longest period of time. However, the study of the total questionnaire showed time spent in Out-Patient Clinic - not in Army Health duties. The committee now questions to interpretation of that question by the Army Health nurse. Do they mean that their time is used maximally or do they mean they are used to maximum capacity as Army Health nurses? The question as we asked it was poorly stated.

Both the nurses being used minimally (14.3%) and partially (28.6%) definitely have other duties assigned as shown previously, which leaves them insufficient time for program organization. The committee thinks this is the reason they evaluated their use as they did.

The committee had eliminated a question from the questionnaire regarding the qualifications of the Army Health nurse. Had we had that information we would have been better able to interpret the above table. We assumed she would have the necessary qualifications by virtue of her

assignment. We have no reason to say she doesn't meet all the qualifications - but there are a few uneasy suspicions in our minds.

The problems the Army Health nurses are encountering, as reported on the questionnaires, are many and varied. For this reason and because we want to recognize each one of them, they were broken down into problem areas to facilitate our recording them in this summary. The areas are as follows:

A. Orientation, Organization and Administration of Program
B. Personnel
C. Space and Equipment

A. Orientation, Organization and Administration

		Number Reported
1.	Orientation	
a.	Families unfamiliar with program	4
b.	Hospital personnel not oriented	4
c.	Lack of interest on part of doctors	2
2.	Organization	
a.	Need for coordination with military social service	1
b.	Difficulties in setting up and adhering to appointment schedules	1
c.	Lack of time for home visits	8
d.	Lack of time for staff conferences	3
e.	Lack of time for school programs	4
3.	Administration	
a.	Lack of cooperation of Commanding Officer and Chief Nurse	3
b.	Case loads in Out-Patient Clinic too heavy for one nurse	10
c.	Army Health nurse transferred without replacement resulting in break down of program	1
d.	Lack of standard referral system	3
e.	No authorized routine orders for nurse	2
f.	Lack of standard records and reports	8

B. Personnel	Number Reported
1. Army Health nurse used as ward relief-breaking the continuity of program	11
2. Army Health nurse used part-time Out-Patient Dept. thus limiting her program activity	10
3. Army Health nurse as special nurse for seriously ill patients causing appointments to be broken	1
4. Need for additional Army Health nurse	4
5. Need for clerical aid	1
6. Need for non-professional help	2
7. Nurse feels programs future very unstable in case of total mobilization	1
8. Friction between two nurses on one program (Senior nurse apparently unwilling to accept suggestions as regards changes in program.)	1
c. Space and Equipment	
1. Lack of equipment for home calls	3
2. Lack of clinic space for counselling	2
3. Lack of transportation for home visits	2
4. Lack of telephones-nurses sharing phones with Out-Patient Dept. and misses calls	2

Seven posts reported no problems, but this was not the true picture when the whole questionnaire was studied.

The great need seems to be orientation to hospital personnel as to the actual duties of the Army Health nurse, as well as to the purpose of the program. Orientation must also be a continuous activity to troops and dependents because of the constant turnover of military personnel.

The vague and varied interpretations of the functions of the Army Health nurse, as well as the absence of standardized routines throughout the Army may be the reason for friction and misunderstanding between doctors and nurses, and between the Army Health nurses themselves.

The lack of standard records and reports adds to the Army Health nurses tasks. It also causes confusion when transferring a nurse from

one program to another. She has to learn a whole new set of records and reports. The committee feels that a gold mine of valuable statistical data is being lost because there is no standard form of records for study. The results of the program as regarding reduction of hospitalization cannot be tabulated.

Many of the Army Health nurses show evidence of becoming discouraged with trying to set up a working program because so much of their time is spent in Out-Patient clinics. Because of the heavy clinic loads they are unable to get out into the homes to teach and supervise, or to hold the instruction classes they believe necessary.

Again our questionnaire was not as clear as we supposed. These areas were reported by Medical Service division, while the ineffective areas (following) were reported by function:

Most Effective Areas	Number Reported
Obstetrics and Gynecology	
Pre-natal home visits	19
Post-partum follow-ups	10
Gynecology-home visits	3
Pediatrics	
Well-baby clinics	10
Pediatric clinics and home visits	7
Communicable diseases - home visits	5
Schools	
Nursery and Dependent Schools (Elementary grades)	7
Others	
Post hospitalization visits	7
Liaison with local Health Agencies	5
Immunization clinics	3
Emotional, vocational and economic guidance	1

The Pediatric and Pre-natal areas seem to be gaining the most benefit from the program and also may be assumed to be the areas in

Which there will be the largest reduction in hospitalization if exact figures could be obtained.

From the survey reports many of the nurses feel that at least a few of the pre-natal cases with complications of pregnancy have avoided hospitalization until their admission for delivery because the Army Health nurses have been able to observe their conditions frequently enough and to supervise their care in the home.

Well-baby clinics are popular with new mothers. They are being taught to care for their babies properly and are given instruction in feeding problems, thereby eliminating some of the new baby admissions which are so frequently feeding cases.

Pediatric clinics plus the follow-up visits in the home also show evidence of reducing children's hospitalization. Many children with communicable disease can be cared for in the home under the supervision of the Health nurse, if the home conditions permit. If there are a number of children in the home, this further reduces the numbers to be hospitalized. Most mothers seem to prefer to take care of the children at home if they have some one to advise and supervise them.

School teachers are gradually beginning to refer children to the Health nurse as the problem becomes better known to them. They pick up small defects in the students not always noticed by the parents. This means treating illnesses earlier before hospitalization becomes necessary. Also many minor defects are corrected by the Army nurse referring them to proper clinics for treatment.

One nurse feels very keenly that the advice she was able to give a mother on ordinary housekeeping, food budgeting and cooking, and even

a little child discipline helped that family more than her actual care of the sick member of the family. Her opinion is that if the nurses had more time to know the family conditions and they could arrange for help from social services, many visits to the clinics could be avoided.

Through the home visits of the Army Health nurse, her teaching and supervision, many patients can be treated on the Out-Patient basis, that would otherwise have to be hospitalized. But most of all of the nurses have the same problem--not enough time for home visits to really show results.

As reported by the Army Health nurses the following resulted from analysis of data:

Most Ineffective Areas	Number Reported
Program Organization and Administration:	
Lack of orientation of personnel who would benefit most by program	6
Program incomplete:	3
Clinic loads too heavy	
Need more doctors and nurses	
No standard reporting system to the nurse of communicable disease	1
No referral system within the hospital for patients to be discharged for follow-up visits by the nurse	1
Supervision	
Families live too far from post for adequate supervision by the nurse	5
Lack of time	
Well-baby supervision	3
Organization and supervision of school programs	2
Home visits to know families and their needs	1

Class Instruction for Mothers	Number Reported
Pre-natal and well-baby classes not attended by mothes because they live too far from post	4

Miscellaneous

Military needs crowding dependents out of clinics	1
Clinics spaces inadequate for classes	1
Program not observed long enough	2

The evaluation made by the Army Health nurses themselves as to the effective and ineffective areas in their programs, as compiled in this study should prove most encouraging to them. The effective areas far out-weigh the ineffective ones. Many of the problem areas are actually out of the control of the nurses, as living conditions, distance of homes from the post and over-crowded clinics.

However, the nurses still feel there are many who should be using this program if they were aware of it. To us, this means the nurses are sincerely interested in their programs, and are more than willing to do even more to enlarge their programs, but the need for more nurses is very clearly stated.

A comparison of the effective and ineffective areas shows amazing progress in their programs since they have been established, in spite of the problems encountered.

Suggestions for a More Successful Program as made by the Army Health nurses.

Topmost on the long list of suggestions for improvement of the Army Health nurse program, is that intensive orientation be conducted, both to the individual health nurse and to all using and contributing agencies.

Standardization of the total program was an equally important suggestion. Requests for standard operating procedures to include records, reports and techniques were cited. There were numerous requests for a technical manual which could be used as a guide, both in establishing the program and in later administration.

Where the program had been in effect the longest, there were requests for additional help, including that of clerical help, additional Health nurses and assignment of non-professional help. In line with this was one suggestion on transfer policy which would insure better continuity. A departing Army Health nurse should not leave her station until she had been given ample time to orient her replacement to the program.

Nurses expressed a sincere desire for administrative cooperation. There were numerous requests for direct assignment to the Post Surgeon and for better liaison with the Chief Nurse.

A need for an educational program was pointed up by several nurses. Some asked for refresher courses, others suggested conferences as a means of exchange of ideas and help in problem solving. There were also several requests for program evaluation criteria, which could be utilized in this field.

It was also suggested by several that a survey be conducted of the posts, camps and stations to determine the need for an Army Health Nursing Service, prior to the establishment of the program. Also, that more adequate physical space and clinical facilities be allotted to the nurse, and that funds be made available to purchase non-standard items of equipment which are frequently needed. Where transportation has

been a problem the nurses have asked that she be granted mileage for using privately owned vehicles.

The need for guidance and supervision was felt keenly by most of the nurses engaged in this program.

Committee's Recommendations

A careful analysis was done on the total study by the members of the committee, and the following recommendations are submitted:

1. That a more stabilized, continuous orientation program be conducted to all military personnel about the Army Health Service and what its functions are.

2. That a procedure manual be formulated and provided to each nurse engaged in the Army Health program.

3. That standardized policies be written, and be flexible enough to meet the implementation needs of the program variances at different installations - as an SR to 40-50.

4, That a standardized form of records and reports be established throughout all Army Health programs.

5. That the Army Health nurse be assigned by published orders as an Army Health Nurse by MOS, with definite designation of line of responsibility.

6. That a program of supervision be afforded nurses in this program by a competent, qualified consultant Health nurse in the Surgeon General's Office and/or a supervisor Health nurse available within each Army area.

7. That staff conferences be arranged so that periodically

all Health Service nurses could meet as a group for evaluation of the progress of their programs, and new ideas be incorporated in the service.

8. That the Army Health nurse be utilized in the full capacity of her function and not used as relief nurse within the hospital.

a. That she be given permanent counselling and teaching spaces.

9. That a further study be made of the program. We suggest obtaining the following data which would have been most helpful in this study:

a. Who does the Army Health nurse's efficiency report?

b. The qualifications of the Army Health nurse.

c. To whom is she assigned on her orders?

10. That a local committee be formed at each installation composed of Chief Nurse, Army Health Nurse, member or members of local health agency, Chief of Preventive Medicine (if available), and representative staff nurses or supervisors to aid in developing the program.

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